IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 007465

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***
*Amended pursuant to section 76 of the **Coroners Act 2008** on 12 August 2026*[1]

Findings of:	Coroner Sarah Gebert
Deceased:	Nicholas James Muggleton
Date of birth:	1 April 1982
Date of death:	22 October 2025
Cause of death:	1(a) Drowning
Place of death:	Frankston Beach Frankston, Victoria
Key words:	*Drowning, surf, severe weather, Frankston Pier, flotation devices*

[1] This document is an amended version of the Finding into the death of Nicholas James Muggleton dated 27 July 2026. Amendments have been made to paragraphs 16 and 17 pursuant to section 76(c) of the *Coroners Act 2008* (Vic).

INTRODUCTION

1. On 22 October 2025, Nicholas James Muggleton was 43 years old when he drowned attempting to rescue a friend caught in rough waters at Frankston Beach.

2. At the time of his death, Nicholas lived in Frankston.

THE CORONIAL INVESTIGATION

3. Nicholas' death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. Victoria Police assigned Senior Constable Shannon Mulholland to be the Coroner's Investigator for the investigation of Nicholas' death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into Nicholas' death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Background

8. Nicholas was born in Wollongong, New South Wales where he lived until his family moved to Victoria in 1990. His mother Valinda described him as a happy and social child. As a teenager, he was an accomplished skateboarder for which he went on to secure sponsorships. Nicholas was a talented artist, and at the time of his death he was pursuing a career in the industry.

9. In 2021, Nicholas moved into an apartment in the former Ambassador Hotel in Frankston. He was close friends with another resident, Calum McCombie (**Calum**), and quickly became involved in the community.

10. Nicholas was an experienced swimmer and surfer. He had travelled to Indonesia and Hawaii for surfing trips and regularly surfed at Bells Beach and Torquay. In recent years, he had been teaching Calum how to surf.

11. Nicholas' medical history included schizoaffective disorder and schizophrenia which were well managed with medication. He had a history of substance use including marijuana and methamphetamine. On 21 October 2025, Nicholas had his final consultation with his general practitioner, who described him as clinically stable, in good spirits, and demonstrating good insight into his condition.

12. According to Valinda, Nicholas was in a good place at the time of his death. He had made promising progress with his mental health, and he and Calum were discussing moving out of the Ambassador into a house together.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

13. On the afternoon of 22 October 2025, Nicholas and Calum attended Frankston Beach intending to surf. They regularly surfed at this location.

14. On this day, a low-pressure system caused severe weather conditions in Victoria, with the Bureau of Meteorology issuing warnings throughout the day for damaging and locally destructive winds peaking throughout the afternoon. The Bureau of Meteorology recorded north westerly winds at 48 kilometres per hour at 3.00pm at Frankston Beach, with a maximum wind gust speed of 87 kilometres per hour (south westerly) recorded just after

6.00pm. Witnesses described very strong winds and turbulent waters, with large waves pounding against, and washing over, the pier.

15. Frankston Pier is 220 meters long and is a popular fishing and swimming location. Jumping and diving off the pier is prohibited, and signage warns of submerged objects and sandbars, strong currents, and variable depth. Frankston Beach is patrolled by volunteer and paid lifeguards at certain times during the summer months. It was not patrolled on this day.

16. At about 4.00pm, Nicholas and Calum walked onto the pier. Calum made his way to the end of the pier with a surfboard. Sometime later Calum found himself in the water but the circumstances in which he did so are not clear from the available evidence.[3]

17. A witness observed Nicholas shouting, waving his arms, and pointing into the water. As the witness began to approach, he saw Nicholas remove his coat, climb over the railing, and jump into the water. Calum was face up in the water separated from his surfboard, which had broken in half.[4]

18. Nicholas attempted to swim towards Calum. The witness called emergency services and watched as Nicholas and Calum drifted away from the pier to the south. He quickly lost sight of them due to the poor weather conditions.

19. Victoria Police responded, arriving from about 4.40pm. At about 5.10pm, a police helicopter located Nicholas and Calum approximately 100 metres from the pier and extracted them from the water. The helicopter transported Nicholas and Calum to a nearby football oval, where Ambulance Victoria paramedics verified death.

20. The Coroner's Investigator noted that there were adverse weather conditions that day, with witnesses *stating how the wind was howling and waves* [were] *coming up and over the pier at the time.* In addition, that whilst the police believe that both Calum and Nicholas were confident around the water, *the adverse weather conditions created a situation where even the most accomplished swimmer would have struggled in the water.*

[3] This paragraph has been amended pursuant to section 76(c) of the *Coroners Act 2008* (Vic).
[4] This paragraph has been amended pursuant to section 76(c) of the *Coroners Act 2008* (Vic).

Identity of the deceased

21. On 30 October 2025, Nicholas James Muggleton, born 1 April 1982, was visually identified by his mother, Valinda Muggleton.

22. Identity is not in dispute and requires no further investigation.

Medical cause of death

23. Forensic Pathologist, Dr Chong Zhou, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 23 October 2025 and provided a written report of her findings dated 7 November 2025.

24. The post-mortem examination was consistent with the reported circumstances and showed no evidence of any significant injuries which may have contributed towards death.

25. A post-mortem computed tomography (CT) scan showed no evidence of acute skeletal trauma.

26. Toxicological analysis of post-mortem samples identified the presence of ethanol (alcohol) at a blood alcohol concentration of 0.09g/100mL[5] and high levels of tetrahydrocannabinol (THC) and its metabolites.[6] Also detected were prescription medications zuclopenthixol,[7] venlafaxine,[8] and diazepam[9]

27. Dr Zhou provided an opinion that the medical cause of death was *"1(a) Drowning"*.

28. I accept Dr Zhou's opinion.

FAMILY CONCERNS

29. On 18 May 2026, Nicholas' father David emailed the court raising a concern about the lack of emergency flotation devices on Frankston Pier at the time of Nicholas' death.

[5] In Australia, it is illegal for full license holders to drive with a blood alcohol concentration ≥ 0.05 g/100 mL.
[6] Delta-9-tetrahydrocannabinol (THC) is the active form of cannabis (marijuana). Persons under the influence of cannabis experience impaired cognition (reasoning and thought), poor vigilance, and impaired reaction times and coordination. Epidemiological studies have shown that recent use of cannabis increases crash risk when driving motor vehicles. This risk starts to become apparent at around 5 ng/mL, however, a substantial elevated risk occurs at higher concentrations (>10 ng/mL).
[7] Zuclopenthixol is a thioxanthene derivative indicated for schizophrenia.
[8] Venlafaxine is indicated for the treatment of depression.
[9] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.

FURTHER INVESTIGATION

30. Given David's concerns, I obtained further information from Life Saving Victoria and Parks Victoria about the use of publicly accessible flotation devices at Frankston Pier.

Life Saving Victoria

31. On 12 June 2026, Dr Hannah Graefe, Manager of Research and Evaluation, provided a written response to the Court on behalf of Life Saving Victoria. Dr Graefe advised that Life Saving Victoria was not aware of any documented reasons as to why publicly accessible flotation devices were not installed at Frankston Pier. She explained Life Saving Victoria completed a risk assessment for Frankston City Council in 2020, which encompassed Frankston Beach and Pier. That risk assessment identified public rescue equipment, among other preventative measures, as a potential risk treatment option.

32. Dr Graefe explained there are different types of public rescue equipment available and recommended for different locations and purposes. These can include rescue tubes, life rings, ropes, throw bags and rescue buoys.

33. After reviewing the available evidence, Life Saving Victoria was of the view that a flotation device, such as a rescue tube or life ring, may have assisted in preserving Nicholas' life. Dr Graefe explained, for example, Nicholas could have thrown a non-contact rescue device to Calum and remained out of the water, or he could have used a contact rescue device to stay afloat while attempting the rescue, or while awaiting rescue himself. However, Dr Graefe noted the water conditions at the time, and the fact that Calum had already lost his surfboard in the water. In these circumstances, Life Saving Victoria was unable to conclude with certainty whether a flotation device would have saved Nicholas' life.

34. Dr Graefe advised the Court that Life Saving Victoria supports the installation of publicly accessible flotation devices at Frankston Pier and other locations where risk assessments indicate they may be of benefit to alleviate the drowning risks posed by the location. Life Saving Victoria identified Rye Pier, Altona Pier, Rosebud Pier and Portarlington Pier as the locations of other drownings in recent years and at which it considered publicly accessible flotation devices would be of benefit to improve the safety of the public.

Parks Victoria

35. On 10 July 2026, Sarah Auld, Director – Maritime and Waterways Directorate, provided a written response to the Court on behalf of Parks Victoria. Ms Auld advised the Court that Parks Victoria's position on publicly accessible flotation devices at Frankston Pier would need to be informed by a site-specific assessment of the risks and expected safety benefits at that location.

36. Ms Auld advised that Parks Victoria does not adopt a universal approach to the installation of publicly accessible flotation devices on piers and jetties but has applied a risk-based approach since 2004. As such, flotation devices may be installed where site-specific assessments identify a clear benefit. This includes locations with high visitation, remote settings, or areas with an elevated risk profile. Ms Auld advised that Parks Victoria considers this approach to be consistent with international drowning prevention frameworks[10] and aligned with broader Victorian water safety findings,[11] which highlight limitations associated with access, maintenance and misuse of public flotation devices, as well as the potential risk to untrained bystanders.

37. Ms Auld explained Parks Victoria prioritises preventative measures to manage water safety risk, which focus on reducing the likelihood of people entering the water or being unable to exit safely. These measures include safety ladders, handrails, edge treatments, fencing, lighting and clear signage, supported by education and community awareness initiatives, including targeted messaging on the risks associated with pier jumping and unsafe water activities.

38. Ms Auld confirmed Parks Victoria complies with the applicable Australian Standards for piers and jetties, which do not require the installation of lifebuoys. She emphasised Parks Victoria remains committed to the safety of visitors to its piers and jetties and will continue to review and apply appropriate safety measures informed by evidence, risk and evolving best practice.

[10] International Life Saving Federation's 2015 Framework *(Drowning Prevention Strategies: A framework to reduce drowning deaths in the aquatic environment for nations/regions engaged in lifesaving)*.
[11] Inspector-General for Emergency Management's (IGEM) 2024 *Review of Victoria's water safety arrangements*.

FINDINGS AND CONCLUSION

39. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Nicholas James Muggleton, born 1 April 1982;

    (b) the death occurred on 22 October 2025 at Frankston Beach, Frankston, Victoria, from drowning; and

    (c) the death occurred in the circumstances described above.

40. Having considered all of the circumstances, I am satisfied that Nicholas' death occurred as a result of an accidental drowning following his attempt to rescue his friend who was already struggling in the water.

41. While publicly accessible flotation devices at Frankston Pier may not have prevented Nicholas' death, I am satisfied that the availability of such devices may be of benefit to alleviate the drowning risks posed by the location, especially at times when lifesavers and lifeguards are not patrolling.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. That Parks Victoria work with Life Saving Victoria to undertake a risk assessment of Frankston Pier to determine the viability of installing publicly accessible flotation devices at this location.

2. That Parks Victoria work with Life Saving Victoria to review other piers under its jurisdiction where drowning incidents have occurred to undertake risk assessments to determine the viability of installing publicly accessible flotation devices at these additional locations.

I convey my sincere condolences to Nicholas' family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Valinda Muggleton, senior next of kin

David Muggleton, senior next of kin

Kathleen Jensen, Bayside Health Peninsula

Parks Victoria

Life Saving Victoria

Senior Constable Shannon Mulholland, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 27 July 2026

Re-signed: 12 August 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.